

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0529 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00526

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 4 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hosp.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LEROY ALLEN				4. DATE OF DEATH Month Day Year Jan. 1, 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Info.				14. MOTHER'S MAIDEN NAME Wilhelmina Allen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-12-7973		17. INFORMANT Mrs. Laura Allen Ches. City, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X CORONARY THROMBOSIS DUE TO (b) Pulmonary Embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 Hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Jan. 2, 1960			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 4, 1960		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME 244 N. 2nd St. Elkton, Md.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

Item 20 Film 263 5-12-60 ans													
2710 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Item 4 Film G262 5/12/60 lwk													
Reg. Dist. No. 6440396													
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 11 mo 1 day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31064					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 405 Seagull Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First HENRY Middle (NMI) Last BACOTE				4. DATE OF DEATH Month January Day unknown Year 19 60 ?									
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-13-32		9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Abbuts Bacote				14. MOTHER'S MAIDEN NAME Rebecca Manning									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW - Korean				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Abbuts Bacote, Mother, 1717 Howard St. Hartsville, S. C.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 929.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Unk. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unk.		20f. (City or town) Unk. (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE R. C. DODSON				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 5-3-60					
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 5/4/60		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) Hartsville, S. C. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Pennington				ADDRESS Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE MAY 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MAKYL AND STATE DEPARTMENT OF HEALTH-SALMONELLA

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00527

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Cecil</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Md.</span> b. COUNTY <span style="font-size: 1.2em;">Cecil</span>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Rural Elkton</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">14 Yrs</span>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">X Rural Elkton</span>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Rte. # 40</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">/ Rte. # 40</span>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">HULDA S. BOLLENBACHER</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">January</span> Day <span style="font-size: 1.2em;">18</span> Year <span style="font-size: 1.2em;">1960</span>						
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Jan 21, 1891</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">68 yrs.</span>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">House wife</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">at Home</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Kansas</span>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Carl Schnieder</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">No Info.</span>						
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mr. Edward Bollenbacher</span>				Address <span style="font-size: 1.2em;">Nr. Elkton, Md</span>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Accute Coronary Occlusion</span>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="font-size: 1.2em;">Diabetes</span>            DUE TO (c)         </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH  <span style="font-size: 1.2em;">Immediate</span> </div> </div>										
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour <span style="font-size: 1.2em;">a. m.</span> <span style="font-size: 1.2em;">p. m.</span> Month <span style="font-size: 1.2em;">19</span> Day <span style="font-size: 1.2em;">19</span> Year <span style="font-size: 1.2em;">19</span>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">R. C. Dodson</span>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <span style="font-size: 1.2em;">Jan. 18, 1960</span>			
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">R. C. DODSON M.D.</span>					<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>			<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">Jan 21, 1960</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Gilpin Manor Mem. Park</span>			<b>22d. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Nr. Elkton, Maryland</span>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">PIPPIN FUNERAL HOME</span>					<b>ADDRESS</b> <span style="font-size: 1.2em;">Elkton, Md</span>		<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">JAN 20 '60</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">C. L. Evans</span>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File Pages 1 and 2 with the registrar prior to burial, cremation or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
RACE [Faint text, possibly "White"]		BIRTH DATE [Faint text, possibly "01/01/1920"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		DATE OF DEATH [Faint text, possibly "03/15/1965"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
MANNER OF DEATH [Faint text, possibly "Natural"]		SIGNATURE OF EXAMINER [Faint signature]		DATE OF SIGNATURE [Faint text, possibly "03/15/1965"]	
SIGNATURE OF WITNESS [Faint signature]		DATE OF SIGNATURE [Faint text, possibly "03/15/1965"]		SIGNATURE OF SECOND WITNESS [Faint signature]	
DATE OF SIGNATURE [Faint text, possibly "03/15/1965"]		SIGNATURE OF SECOND WITNESS [Faint signature]		DATE OF SIGNATURE [Faint text, possibly "03/15/1965"]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

00528

0548

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2025 Maryland Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last LOREN A. BRAINARD		4. DATE OF DEATH Month Day Year January 14 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-17
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY Television	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Brainard		14. MOTHER'S MAIDEN NAME Essie Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address (Mother) Essie Brainard, 2025 Maryland Ave. Balto, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, cause undetermined DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, residual type		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 30, 1959, to January 14, 1960, and that death occurred at 5:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Seymour Goldgraben, M.D.		M.D. V.A. Hospital, Perry Point, Md. 1-14-60	
PHYSICIAN'S NAME (Type) SEYMOUR GOLDGRABEN		Chief, Medical Service	
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	22b. DATE THEREOF 1-18-60	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William Cook Fun.Home, 1217 St. Paul St. Baltimore, Md.		24a. REC'D BY REGISTRAR DATE JAN 18 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

51405

• *Staphylococcus aureus*

544



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 15yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle G. Last CANN		4. DATE OF DEATH January 19 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Fair Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gilbert CANN		14. MOTHER'S MAIDEN NAME MARY Steele	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Mary Bowlsbey, 230 W. Main St, Elkton, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cerebral hemorrhage DUE TO (b) Arteriosclerotic hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unknown		INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 15, 1959, to Jan. 19, 1960, that I last saw the deceased alive on Jan. 18, 1960, and that death occurred at 2:20 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.		ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 1/19/60	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.		Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/22/60	22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	22d. LOCATION (City, town, or county) (State) Lewisville, Cecil, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks Elkton, Md.		24a. REC'D BY REGISTRAR DATE JAN 28 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

12 AM 21

May 21

Gilbert

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## CERTIFICATE OF DEATH

Reg. Dist. No.

00530

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wilford Lester Carr		4. DATE OF DEATH Month Day Year Jan 12 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1902
9. AGE (In years lost birth day) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Conowingo Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William P. Carr		14. MOTHER'S MAIDEN NAME Deliah Harman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES Unknown		16. SOCIAL SECURITY NO. 218-05-3348	
17. INFORMANT William P. Carr		Address Conowingo, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Rupture abdominal aortic aneurysm DUE TO (b) Aneurysm descending aorta DUE TO (c) Atherosclerosis, generalized, severe			INTERVAL BETWEEN ONSET AND DEATH 21 hrs. unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 11, 1960, to Jan 12, 1960, that I last saw the deceased alive on Jan 12, 1960, and that death occurred at 6:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Tillman D. Johnson M.D.		ADDRESS (Street, city or town, state) 123 Slingerly Ave	
PHYSICIAN'S NAME (Type) Tillman D. Johnson		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-15-1960	22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cem.	22d. LOCATION (City, town, or county) (State) Peachbottom, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Vernon E. McMullen		ADDRESS Rising Sun Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JAN 15 '60		Arthur E. Kneass	

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00531

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right; font-size: 1.5em;">0549</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point,</b> c. LENGTH OF STAY IN 1b <b>2hrs. 50min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Magnolia</b> <span style="float: right;">12X-2</span> d. STREET ADDRESS <b>Box 645N</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>DAVID</b> Middle <b>D.</b> Last <b>CHASE</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>22</b> Year <b>19 60</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>December 15, 1891</b>
<b>9. AGE</b> (In years last birthday) <b>68</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>WILLIAM CHASE</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY DENNISON</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give year or dates of service) <b>Unknown</b>	
<b>17. INFORMANT</b> Address <b>Lotti Chase, Wife, Box 645, Magnolia, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ 420.0			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>1957</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <i>R. C. Dodson</i>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <b>R. C. DODSON, M.D.</b>		<b>DATE SIGNED</b> <b>January 23, 1960</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Jan. 26, 1960</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Eb enezzer Baptist Church</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Joppa, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOWARD K. MC COMAS &amp; SON, Abingdon, Maryland</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE JAN 27 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hines</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

INVESTIGATING STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0240

**NOTING PHYSICIAN:** The law requires that the doctor  
a hospital or attending physician.  
After this certificate has been signed by the  
physician, the body must be transported to the funeral home or the burial-transit permit.

**TO HOSPITAL OR**  
may be retained if  
**TO FUNERAL DIRECTOR**  
page 3 should



be detached for use as the burial record. The attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0220

Michigan

Ann Arbor

Walter and Catherine

STERN (M)

Wife of Walter

Ann Arbor

Ann Arbor

Ann Arbor

Not available from records

Yes

No

Unknown

Walter and Catherine

Walter and Catherine

Walter and Catherine

Walter and Catherine

Walter and Catherine

June 12

25

January 11

1900

Walter and Catherine

Walter and Catherine

Walter and Catherine

Walter and Catherine

Walter and Catherine

0532  
CERTIFICATE OF DEATH

Reg. Dist. No.

00533

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>11 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 W. Main Street,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Violet Miriam Cook</b>		4. DATE OF DEATH Month Day Year <b>Jan 14 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 20, 1896</b>
9. AGE (in years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Sales-Bakery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Terry</b>		14. MOTHER'S MAIDEN NAME <b>Ann No Info.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>202-07-8819</b>	
17. INFORMANT <b>Mr. Irvin J. Cook, Elkton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic (Recurrent) Arteriosclerotic Heart Disease 10yrs</b> DUE TO (c) <b>Acute Pleurisy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT.</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchiectasis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 JAN., 1960</b> to <b>14 JAN., 1960</b> that I last saw the deceased alive on <b>13 JAN., 1960</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George J. Kreis, Jr.</b>		DATE SIGNED <b>17 Jan 60</b>	
PHYSICIAN'S NAME (Type) <b>George J. Kreis, Jr.</b>		ADDRESS (Street, city or town state) <b>Elkton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-18-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception nr. Elkton, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '60</b>	
ADDRESS <b>Don't see Elkton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1. Name of Deceased: [Illegible]  
2. Sex: [Illegible]  
3. Age: [Illegible]  
4. Date of Birth: [Illegible]  
5. Date of Death: [Illegible]  
6. Place of Death: [Illegible]  
7. Cause of Death: [Illegible]  
8. Signature of Physician: [Illegible]  
9. Signature of Registrar: [Illegible]  
10. Date of Registration: [Illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No.

00534

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 17 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter W Cook				4. DATE OF DEATH Month Day Year January 5 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1889	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Cook				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Mrs. Sophia Nowak Cook, North East (Rural) Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO Pulmonary Edema. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio Vascular Dis.							INTERVAL BETWEEN ONSET AND DEATH 15 min. 2 days 5 days.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1959, to Jan 5, 1960, that I last saw the deceased alive on Jan 4, 1960, and that death occurred at 5:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Luis M. Cuza M.D. North East Md. PHYSICIAN'S NAME (Type) LUIS M. CUZA							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 9, 1960		22c. NAME OF CEMETERY OR CREMATORY New Immaculate Conception Cem.		22d. LOCATION (City, town, or county) (State) Elkton Road Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				24a. REC'D BY REGISTRAR DATE JAN 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Handwritten: John Doe]</p>		<p>2. SEX                  [Handwritten: Male]</p>	
<p>3. AGE                  [Handwritten: 45]</p>		<p>4. DATE OF BIRTH                  [Handwritten: 10/15/1900]</p>	
<p>5. PLACE OF BIRTH                  [Handwritten: Baltimore, Maryland]</p>		<p>6. OCCUPATION                  [Handwritten: Clerk]</p>	
<p>7. MARITAL STATUS                  [Handwritten: Single]</p>		<p>8. CAUSE OF DEATH                  [Handwritten: Heart Disease]</p>	
<p>9. MEDICAL HISTORY                  [Handwritten: High Blood Pressure]</p>		<p>10. DATE OF DEATH                  [Handwritten: 11/1/1945]</p>	
<p>11. PLACE OF DEATH                  [Handwritten: Home]</p>		<p>12. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>13. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>14. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>15. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>16. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>17. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>18. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>19. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>20. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>21. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>22. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>23. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>24. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>25. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>26. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>27. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>28. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>29. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>30. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>31. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>32. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>33. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>34. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>35. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>36. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>37. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>38. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>39. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>40. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>41. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>42. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>43. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>44. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>45. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>46. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>47. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>48. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>49. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>50. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>51. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>52. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>53. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>54. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>55. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>56. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>57. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>58. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>59. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>60. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>61. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>62. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>63. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>64. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>65. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>66. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>67. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>68. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>69. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>70. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>71. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>72. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>73. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>74. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>75. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>76. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>77. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>78. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>79. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>80. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>81. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>82. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>83. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>84. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>85. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>86. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>87. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>88. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>89. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>90. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>91. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>92. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>93. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>94. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>95. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>96. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>97. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>98. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	
<p>99. SIGNATURE OF WITNESS                  [Handwritten: John Doe]</p>		<p>100. SIGNATURE OF DECEASED                  [Handwritten: John Doe]</p>	



## 0534 CERTIFICATE OF DEATH

00555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bikton				c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELLA Middle G. CROUCH Last				4. DATE OF DEATH Month 1-28-1960 Day 19 Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-1901	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Harry Arrants				14. MOTHER'S MAIDEN NAME Wilhemina Pennington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-32-2965		17. INFORMANT Laurence M. Crouch North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of post. inf. cerebellar artery 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arterio sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 months 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year - - - 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - -	
				20f. (City or town) - - -		(County) (State)	
21. I certify that I attended the deceased from 3 Dec., 1959, to 28 Jan., 1960, that I last saw the deceased alive on 27 Jan., 1960, and that death occurred at 4 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner				ADDRESS (Street, city or town, state) Cecil Ave. North East, Md.			
DATE SIGNED 29 Jan. '60							
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-1960		22c. NAME OF CEMETERY OR CREMATORY North East Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE FEB 1 1960	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0535  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b <b>28 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>114 Landing Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>E.</b> <b>CRUIKSHANK</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1900</b>
9. AGE (In years last birthday) <b>59 yrs.</b>		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>17</b> Hours <b>17</b> Min.	11. IF UNDER 24 HRS. Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Davis, West Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Cruikshank</b>		14. MOTHER'S MAIDEN NAME <b>Stella Ketterman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-05-3861</b>	
17. INFORMANT <b>Mrs. Paul E. Cruikshank, Elkton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 18</b> , 19 <b>59</b> , to <b>Jan. 17</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Jan 17</b> , 19 <b>60</b> , and that death occurred at <b>2:45</b> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Edward H. Spivey</b>		ADDRESS (Street, city or town, state) <b>Elkton, Md.</b> DATE SIGNED <b>Jan. 17-60</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-20-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception nr. Elkton, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>Jan 20 '60</b>	
ADDRESS <b>Donald M. Dee Elkton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

052

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1901

28 yrs.

United Hospital

1st Line 2 Days

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point,</b>		c. LENGTH OF STAY IN 1b <b>2yrs7mos3days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>C.</b> Last <b>Eichhorn</b>		4. DATE OF DEATH Month <b>1</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-94</b>
9. AGE (In years last birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>23</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not ascertainable</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not ascertainable</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Eichhorn</b>		14. MOTHER'S MAIDEN NAME <b>Marcella Zinkhan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>216-05-3587</b>	
17. INFORMANT <b>Elizabeth Eichhorn (W)</b>		Address <b>404 E. Joppa Rd. Towson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>430.0</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Rheumatic heart disease, inactive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Subacute bacterial endocarditis in bacteria</b> (c) <b>free state</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>3 yrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-20</b> , 19 <b>57</b> , to <b>1-23</b> , 19 <b>60</b> and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-24-60</b>			
ACTUAL SIGNATURE <b>Thomas P. Thompson</b>		M.D. <b>VA Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Thomas P. Thompson, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	22b. DATE THEREOF <b>1-24-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Towson, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons, Towson, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 29 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 0536 CERTIFICATE OF DEATH

00538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>80 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union ELKTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maxy</u> Middle <u>E</u> Last <u>Evans</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robt. E. Harrigan</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Carr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Thomas Evans</u>		Address <u>Pleasant Hill</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Broncho Pneumonia</u> DUE TO (c) <u>Diabetes + Uremia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/26</u> , 19 <u>59</u> to <u>1/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>60</u> , and that death occurred at <u>9:45 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>205 W. Main St. Md.</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Joseph G. Lanzani</u> M.D.		PHYSICIAN'S NAME (Type) <u>Joseph G. Lanzani</u> <u>ELKTON</u> <u>MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-5-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sharps Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fairhill ELKTON P.O. Cecil MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Grant North East Md</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JAN 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1880

1880



## 0537 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1307 Hollingsworth St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John Perkins Harvey		4. DATE OF DEATH Month Day Year January 23 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1, 1884 75 yrs.
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY General Devel.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Harvey		14. MOTHER'S MAIDEN NAME Eva Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
INFORMANT Mrs. Ethel Harvey, 307 Hollingsworth St.		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CEREBRAL VASCULAR THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL VASCULAR SCLEROSIS (c) ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 days 3 years? 90 days?		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/13, 1960, to 1/23, 1960 that I last saw the deceased alive on 1/23, 1960, and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Stavakis		ADDRESS (Street, city or town, state) 154 W. MAIN Elkton, Md.	
PHYSICIAN'S NAME (Type) PETER STAVAKIS M.D.		DATE SIGNED 1/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/60	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR DATE FEB 1 '60		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

00540

0552

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>6 mos 17 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>411 2nd Street, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cleveland (NMI) Hodge</b>		4. DATE OF DEATH Month Day Year <b>1 30 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-11</b>
9. AGE (In years lost birthday) yrs. <b>49</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Hodge</b>	
14. MOTHER'S MAIDEN NAME <b>Jessie Burney</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>578-03-7987</b>		17. INFORMANT <b>Mrs. Helen Wilson (S)</b> Address <b>411 2nd St. S.E. Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lungs with metastasis to bone,</b> <b>163X</b> DUE TO <b>lymph nodes of chest cavity and abdominal lymph nodes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>nodes</b> DUE TO (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-13</b> , 19 <b>59</b> , to <b>1-30</b> , 19 <b>60</b> , and that death occurred at <b>5:40 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. L. Garey</b>		ADDRESS (Street, city or town, state) <b>VA Hosp. Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY, M.D.</b>		DATE SIGNED <b>1-31-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1-31-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AT5 (4)  
15M 9/58

CERTIFICATE OF DEATH

0553

Washington

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00541  
96

0553

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. STREET ADDRESS <b>Route 1 Box 172A</b>							
3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>J.</b> Last <b>JACOBI</b>				4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-12-97</b>	
9. AGE (In years lost birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		11. IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Advisor (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Patent - Govern-</b>			
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Philip Jacobi (deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Antonette Bonberg (deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Harriett Jacobi, wife, Route 1, Box 172A</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Arteriosclerosis generalized severe</b> DUE TO (c) <b>unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>VA</b> 19 p. m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 9, 1960</b> to <b>January 19, 1960</b> and that death occurred at <b>8:50pM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-21-60</b>							
ACTUAL SIGNATURE <b>J. L. Garey</b>				M.D. <b>V.A. Hospital, Perry Point, Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>				Clinical Pathologist			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>				22b. DATE THEREOF <b>1/25/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>				ADDRESS <b>Havre de Grace, Md.</b>			
24a. REC'D BY REGISTRAR <b>JAN 26 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00542

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">0554</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>Enroute</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 40</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Essex</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clintonville</u> <span style="float: right;">69x-3</span> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Loretta</u> Middle <u>La Mountain</u> Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 24-1901</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>58</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Ausadale Forks, N.Y.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1960</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
13. FATHER'S NAME <u>Martin Ryan</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Katherine Keese</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. Michael Burke, Clintonville, N.Y.</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull with loss of bone and brain</u> DUE TO <u>tissue Fracture right forearm and humerus</u> Conditions, if any, which gave rise to immediate cause (b) <u>Crushed chest, Fracture left Tibia and Fibular</u> (c) <u>and multiple bruises and abrasion over body</u> (a), stating the underlying cause lost. <u>Tire marks on left thigh.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour <u>6:30</u> p.m. <u>1 2 19 60</u> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 40</u> 20f. (City or town) <u>Elkton</u> (County) <u>Cecil</u> (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <u>R. C. Dodson</u> EXAMINER'S NAME (Type) <u>R. C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <span style="float: right;">DATE SIGNED <u>1-3-60</u></span>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> 22b. DATE THEREOF <u>JAN 9, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>HOLY NAME CEMETERY</u> ADDRESS <u>ELKTON MD</u> 22d. LOCATION (City, town, or county) <u>AUSADALE FORKS</u> (State) <u>NEW YORK</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME Donald R. De</u> 24a. REC'D BY REGISTRAR <u>JAN 6 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00543

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY Cecil <span style="float: right;">0555</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b Enroute d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RTE # 40				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Essex c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clintonville 69X-3 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Raymond Joseph La Mountain <b>4. DATE OF DEATH</b> Month Day Year 1 2 1960			<b>5. SEX</b> M <b>6. COLOR OR RACE</b> W <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> 11-8-1902 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) 57 yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Retired Farmer <b>10b. KIND OF BUSINESS OR INDUSTRY</b> Farming <b>11. BIRTHPLACE</b> (State or foreign country) Clintonville, N.Y. <b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.		<b>13. FATHER'S NAME</b> Joseph La Mountain <b>14. MOTHER'S MAIDEN NAME</b> Elizabeth Tebo <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) no (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> Mrs. M. Burke, Clintonville, N.Y. Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812x Fracture base of skull, Crushed right shoulder DUE TO (b) Crushed left side of chest lacerated right eyebrow abrasion of face and nose Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) Hit by automobile <b>20c. TIME OF INJURY</b> Month, Day, Year 1 2 60 Hour a. m. 6 p. m. While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) Route 40 <b>20f. (City or town)</b> Elkton <b>(County)</b> Cecil <b>(State)</b> Md.							
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> EXAMINER'S NAME (Type) R. C. Dodson <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> REMOVAL <b>22b. DATE THEREOF</b> JAN 9 1960 <b>22c. NAME OF CEMETERY OR CREMATORY</b> HOLY NAME CEMETERY <b>22d. LOCATION (City, town, or county)</b> AUSABLE FORKS, NEW YORK <b>22e. ADDRESS</b> ELKTON Md.		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> 1-3-60 <b>24a. REC'D BY REGISTRAR</b> JAN 6 '60 <b>24b. REGISTRAR'S SIGNATURE</b> Arthur S. Francis					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





0538

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>3 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>LEWIS</u> Last <u>LEWIS</u>				4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 23 1886</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter &amp; Paper Hanger</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>William R. Lewis</u>				Address <u>North East, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO <u>Cerebral Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>27 Jan</u> , 19 <u>60</u> , to <u>27 Jan</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>27 Jan</u> , 19 <u>60</u> , and that death occurred at <u>12:20 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cecil Ave. North East, Md</u> DATE SIGNED <u>29 Jan '60</u> ACTUAL SIGNATURE <u>Klaus H. Huebner M.D.</u> PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-30-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton Rural Cecil Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Grant</u> ADDRESS <u>North East, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME [Name]		SEX [Male/Female]	
DATE OF BIRTH [Date]		PLACE OF BIRTH [Place]	
CITY OF DEATH [City]		COUNTY OF DEATH [County]	
STATE OF DEATH [State]		ZIP CODE [ZIP]	
DATE OF DEATH [Date]		TIME OF DEATH [Time]	
PLACE OF DEATH [Place]		CAUSE OF DEATH [Cause]	
MANNER OF DEATH [Manner]		MEDICAL HISTORY [History]	
OCCUPATION [Occupation]		EDUCATION [Education]	
RELIGION [Religion]		MARITAL STATUS [Status]	
SOCIAL SECURITY NUMBER [Number]		MEDICAL INSURANCE [Insurance]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF CORONER [Signature]	
SIGNATURE OF JUDGE [Signature]		SIGNATURE OF CLERK [Signature]	

0556

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>2 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DR. STEPHAN</b> Middle <b>K.</b> Last <b>MAYER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-20-90</b>		9. AGE (In years last birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician-Psychiatrist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>V.A. Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Otto Mayer</b>			
14. MOTHER'S MAIDEN NAME <b>Anna Loewe</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Non-Veteran</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				INFORMANT Address <b>Perry Point, Md. Caecilia Mayer, wife, 1139 Avenue B,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerosis generalized severe</b> DUE TO (c) <b>unknown</b>							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>January 14, 19 60</b> , to <b>January 15, 1960</b> and that death occurred at <b>12:15 am</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. L. Garey</b>				ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-15-60</b>			
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>				Clinical Pathologist			
22a. BURIAL (CREMATION REMOVAL) (Specify)		22b. DATE THEREOF <b>1/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 18 1960</b> DATE		24b. REGISTRAR'S SIGNATURE	

## 3220

Downloaded At: 11:53 11 September 2009

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## 0558 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 1517-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 6410 4th Avenue	
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Norton		4. DATE OF DEATH Month 1 Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-16-1903
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Not ascertainable	
11. BIRTHPLACE (State or foreign country) Aspen, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert L. Norton		14. MOTHER'S MAIDEN NAME Marion E. Norton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 212-14-8787	
17. INFORMANT Robert L. Norton (B) Takoma Park, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage sub-dural, right 331X DUE TO (b) Arteriosclerosis cerebral severe DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 12-10-59 to 1-24-60 and that death occurred at 6:30 PM, from the causes and on the date stated above.	
ACTUAL SIGNATURE J. L. Garey		ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) J. L. GAREY		DATE SIGNED 1-25-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 28, 1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY George Washington Memorial Park, Md.		22d. LOCATION (City, town, or county) (State) Adelphi, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Takoma Funeral Home, 254 Carroll St. Takoma		24a. REC'D BY REGISTRAR DATE JAN 27 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-1-1914

10-1-1914

10-1-1914

10-1-1914

10-1-1914

10-1-1914

10-1-1914

10-1-1914

10-1-1914

10-1-1914

10-1-1914



0546

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Novotny				4. DATE OF DEATH Month Day Year Jan. 5 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1875		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Bohemia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vaclav Kovarnik				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) no		17. INFORMANT Joseph Novotny		Address North East, R.D., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypostatic Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric Ulcer							INTERVAL BETWEEN ONSET AND DEATH 4 days 8 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Jan., 1960, to 5 Jan., 1960, that I last saw the deceased alive on 5 Jan., 1960, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Klaus H. Huebner M.D. North East, Md. 1/8/60							
ACTUAL SIGNATURE Klaus H. Huebner		PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-9-60		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		22d. LOCATION (City, town, or county) (State) North East Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland.		24a. REC'D BY REGISTRAR DATE JAN 11 '60	
				24b. REGISTRAR'S SIGNATURE C. S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0559 CERTIFICATE OF DEATH

00548  
 Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>34 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HENRY</b> First <b>S.</b> Middle <b>POPP</b> Last				4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-25-91</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>3</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>68</b> Days <b>3</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Not Available From Records</b>				14. MOTHER'S MAIDEN NAME <b>Not Available From Records</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-1</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs. A.J. Plantholt</b>				18. ADDRESS (Street, city or town, state) <b>4407 Penhurst Avenue, Baltimore, Md. (Sister)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>491X</b> (c) <b>Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m. <b>10:25AM</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-27-</b> 19 <b>25</b> , to <b>1-29-</b> 19 <b>60</b> , and that death occurred at <b>10:25AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1/29/60</b> DATE SIGNED ACTUAL SIGNATURE <b>Laslo Kajdi</b> M.D. PHYSICIAN'S NAME (Type) <b>LASLO KAJDI, M.D.</b> <b>VA HOSPITAL, PERRY POINT, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 4/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry Armstrong</b>		ADDRESS <b>4204 Ridgeland Rd</b>		24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

0553

ASSISTANT ATTORNEY GENERAL

DEPT. OF JUSTICE

WASHINGTON, D.C.

FOR VOUCHER FROM RECORDS

RECEIVED

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RECEIVED

RECEIVED

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RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

00549

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>0560</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>		c. LENGTH OF STAY IN 1b <b>4 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Aikin</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>S.</b> Last <b>Price</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1870</b>
9. AGE (In years last birthday) yrs. <b>89</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Vachel Price</b>		14. MOTHER'S MAIDEN NAME <b>Millicent Simperts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Mrs. W.B. Thomas, Perryville, Md. Rural</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 5, 1955</b> , to <b>1-9</b> , 1960, that I last saw the deceased alive on <b>1-8</b> , 1960, and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G.H. Richards Jr.</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Perryville, Md. 1-9-60</b>	
PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr., M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-11-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Bank Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Calvert, Cecil Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson, Son</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 12 '60</b>	
ADDRESS <b>Perryville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

doi:10.1017/S0022292412001942

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0528

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>		c. LENGTH OF STAY IN 1b <u>7 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MORGAN NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN M. REED JR.</u>		4. DATE OF DEATH <u>JANUARY 10, 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2, 1876</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN M. REED</u>		14. MOTHER'S MAIDEN NAME <u>EMILY S. SMITHERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HELEN H. REED</u>		Address <u>CHES. CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC CARDIO-VASCULAR RENAL DISEASE</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>46</u> , to <u>JAN 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 10</u> , 19 <u>60</u> , and that death occurred at <u>10:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Henry U. Davis</u> M.D.		PHYSICIAN'S NAME (Type) <u>HENRY U. DAVIS MD</u> <u>CHESAPEAKE CITY MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JAN 13, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>CHESAPEAKE CITY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME Donald R. Du</u> ADDRESS <u>ELKTON, MD</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

055

STATE OF NEW YORK

County of ...

City of ...

I, the undersigned, a duly qualified and licensed ...

do hereby certify that ...

... died on the ... day of ...

at the age of ... years ...

... after a illness of ... days ...

... at the residence of ...

... in the presence of ...

... and ...

... and ...

... and ...

... and ...

... and ...

... and ...

... and ...

0539

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ELKTON</u>			
c. LENGTH OF STAY IN 1b <u>6 DAYS</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSP</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMILY E. Reeves</u>				4. DATE OF DEATH Month Day Year <u>JAN. 8 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 23, 1927</u>	
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ELKTON, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EMEL CEBULA</u>				14. MOTHER'S MAIDEN NAME <u>ESTHER VANDERGRIFF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-22-4215</u>		INFORMANT <u>WILEY H. REEVES</u>		Address <u>ELKTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Myeloid Leukemia</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>6 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2 Jan</u> , 19 <u>60</u> , to <u>8 Jan</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8 Jan</u> , 19 <u>60</u> , and that death occurred at <u>6:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George J. Kreis Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Elkton, Md</u> DATE SIGNED <u>1/8/60</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE J. KREIS JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 12, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>UNION, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>Elkton Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WESTLAND WATER OF AVALON - BALTIMORE, MD

*[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and location.]*

0540

## CERTIFICATE OF DEATH

00552

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irvin Middle S. Reynolds Last		4. DATE OF DEATH Month 1 Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Basket Maker & Painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North East, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sylvester S. Reynolds		14. MOTHER'S MAIDEN NAME Katherine Grant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-8051	
17. INFORMANT Mrs Edith Goodnow Reynolds North East Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia (3) 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 9 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 29, 1959, to Jan 20, 1960, that I last saw the deceased alive on Jan. 20, 1960, and that death occurred at 7:55a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 2338 E. Main Street DATE SIGNED 1/20/60	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-1960	22c. NAME OF CEMETERY OR CREMATORY North East Methodist	22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East, Maryland		24a. REC'D BY REGISTRAR DATE JAN 25 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hays			

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Signature of declarant: [illegible]  
6. Date of statement: [illegible]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG255 2-4-60 et

## CERTIFICATE OF DEATH

00553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>VIOLET</b> Last <b>SAMUELS</b>				4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 5 1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>David J. Johnson</b>			
14. MOTHER'S MAIDEN NAME <b>Ellen</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Amanda E. Samuels North East, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral accident</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Coronary</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 years</b> <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, locatory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12/3</b> , 19 <b>56</b> , to <b>1/29</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/28</b> , 19 <b>60</b> , and that death occurred at <b>1 A.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James L. Johnson</b>				ADDRESS (Street, city or town, state) <b>2455 E. High St, Elkton, Md.</b>			
DATE SIGNED <b>1/30/60</b>				PHYSICIAN'S NAME (Type) <b>James L. Johnson</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-2-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Zion Rural Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARINE AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00554

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North East</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>BAIRY</i> Middle <i>BOY</i> Last <i>SHOCKLEY</i>				4. DATE OF DEATH Month <i>1</i> Day <i>23</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-23-1960</i>	9. AGE (In years last birthday) yrs. <i>8</i>	IF UNDER 1 YEAR Months <i>8</i> Days <i>8</i>		IF UNDER 24 HRS. Hours <i>8</i> Min. <i>00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Russell William Shockley</i>				14. MOTHER'S MAIDEN NAME <i>Rose Marie Ball</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT Address <i>Rose Marie Shockley North East Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> <i>769.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Maternal Amnionitis - premature rupture of membranes and partial premature separation of placenta</i> (c) <i>10 days</i>						INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>-</i> o. m. <i>-</i> p. m. <i>19</i>	Month <i>-</i>	Day <i>-</i>	Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <i>23 Jan., 1960</i> , to <i>23 Jan., 1960</i> , that I last saw the deceased alive on <i>23 Jan., 1960</i> , and that death occurred at <i>6:30 P. M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Klaus H. Huchner</i> M.D.				ADDRESS (Street, city or town, state) <i>North East Md</i> DATE SIGNED <i>1/23/60</i>			
PHYSICIAN'S NAME (Type) <i>Klaus H. Huchner M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>1-25-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>North East Mcdaniel</i>		22d. LOCATION (City, town, or county) (State) <i>North East Cecil Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Joseph R. Brown North East Md</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 27 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2065213XU2



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00555**

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>0543</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7 Collins Court</b>		d. STREET ADDRESS <b>7 Collins Court</b>	
3. NAME OF DECEASED (Type or print) <b>Levi M Shockley</b>		4. DATE OF DEATH <b>1 29 19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-25-1889</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Fruitland, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Shockley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Shockley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>717-07-5346</b>	
17. INFORMANT <b>Rev. Shockley, Wilmington, Del.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Angine for several years</b> (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-29-60</b>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/3/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Fruitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edw. R. Bell</b>		ADDRESS <b>909 Poplar St.</b>	
24a. REC'D BY REGISTRAR <b>FEB 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0544 CERTIFICATE OF DEATH

00556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>UNION HOSPITAL</b>		1d. STREET ADDRESS <b>115 E. HIGH STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALICE</b> First <b>L. SINGLETON</b> Middle <b>L.</b> Last		4. DATE OF DEATH <b>JANUARY</b> Month <b>9</b> Day <b>1960</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 2, 1910</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY GREEN</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA BIDDLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
INFORMANT <b>WILLIAM W. SINGLETON</b> Address <b>ELKTON, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease and cardiomegaly</b> (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>S. Ralph Andrews, Jr.</b> attended the deceased from <b>June 1, 1959</b> to <b>Jan. 9, 1960</b> , that I last saw the deceased alive on <b>Jan. 9, 1960</b> , and that death occurred at <b>6:20a</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>233 E. Main Street</b> DATE SIGNED <b>1/9/60</b>	
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>S. RALPH ANDREWS, JR., M.D.</b>		<b>Elkton, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 12, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GILPIN MANOR MEM. PARK</b>		22d. LOCATION (City, town, or county) (State) <b>NR. ELKTON, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b> ADDRESS <b>Donald Th. Rue Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 15 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 96

00557

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <span style="float: right;">0561</span>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>26yrs.7mo.6days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>			d. STREET ADDRESS <b>North Uumberland</b>		
3. NAME OF DECEASED (Type or print) First <b>EDGAR</b> Middle <b>D.</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-2-98</b>		9. AGE (In years last birthday) <b>61</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surveyor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James E. Smith</b>			14. MOTHER'S MAIDEN NAME <b>Emma McNeir</b> <del>Gertrude Smith (Maiden name unknown)</del>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Margaret Groves(S) Box 84, Charmian, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation by food</b> <b>9217</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Food found in Bronchi</b> (c) <b>Food found in Bronchi</b> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>7:40</b> 1-27-60 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>V.A. Hospital, Perry Point, Maryland</b>	
20f. (City or town) <b>Perry Point, Maryland</b>		20g. (County) <b>Washington</b>		20h. (State) <b>D. C.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R. C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-27-60</b>	
EXAMINER'S NAME (Type) <b>R. C. DODSON</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>	
22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>		22e. (State) <b>D. C.</b>		22f. (City, town, or county) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Grove</i>		ADDRESS <b>Home, Waynesboro, Pa.</b>		24a. REC'D BY REGISTRAR <b>JAN 29 '60</b> DATE	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Date of Death		03-11-1900	
Place of Death		At Home	
Name of Deceased		JAMES E. SMITH	
Age		45	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		Government	
Cause of Death		Heart Disease	
Time of Death		11:00 AM	
Signature of Medical Examiner		J. E. SMITH	
Signature of Coroner		W. I. GROVES	
Signature of Registrar		J. E. SMITH	
Signature of Burial Officer		J. E. SMITH	
Signature of Undertaker		J. E. SMITH	
Signature of Minister		J. E. SMITH	
Signature of Priest		J. E. SMITH	
Signature of Rabbi		J. E. SMITH	
Signature of Imam		J. E. SMITH	
Signature of Other		J. E. SMITH	

RECORDED IN 3114 BOW

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00558

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		0557		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>enroute</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		1437-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 40</b>				d. STREET ADDRESS <b>113 Maple Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b>		Middle <b>William</b>		Last <b>Spencer</b>		4. DATE OF DEATH Month <b>1</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 11, 1938</b>	
9. AGE (In years last birthday) <b>22</b> yrs.		IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min.		IF UNDER 24 HRS. Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Vita Food</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph P. Piazza</b>	
14. MOTHER'S MAIDEN NAME <b>Thelma Kennard</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-32-1859</b>		17. INFORMANT <b>Mrs. Eva Long</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Base of skull and</b> DUE TO (b) <b>Fractured neck</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>Fractured neck</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Hit another car while driving in wrong lane</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hit another car while driving in wrong lane</b>		20c. TIME OF INJURY Month, Day, Year <b>1 23 1960</b> Hour <b>6-35</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40</b>		20f. (City or town) <b>Elkton</b>		(County) <b>Cecil</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>1-24-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-26-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>				ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>AN 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>				24c. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		TIME OF DEATH	
JAMES E. HARRIS		Male		35		11-25-55		10:30 AM	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1100 N. E. St.		Police Officer		Myocardial Infarction		Natural		Home	
FATHER		MOTHER		SPOUSE		CHILDREN		OTHER RELATIVES	
J. H. Harris		M. J. Harris		W. J. Harris		J. E. Harris		M. E. Harris	
EDUCATION		RELIGION		RACE		COLOR		BLOOD TYPE	
High School		Catholic		White		White		O+	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
None		None		None		None		None	
HISTORICAL FACTS		PHYSICAL EXAMINATION		LABORATORY EXAMINATION		TOXICOLOGY		OTHER	
None		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		OFFICE	
J. E. Harris		11-25-55		10:30 AM		Home		Baltimore, Md.	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>2yrs9mos3days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1741 - 8th Street, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDDIE</b> Middle <b>(NMI)</b> Last <b>STOKES</b>		4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1896</b>
9. AGE (In years last birthday) <b>63</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Stokes</b>		14. MOTHER'S MAIDEN NAME <b>Janie Coleman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW-I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Cordelia Stokes, Daughter,</b>		18. ADDRESS <b>431 M St., N.W. Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Azotemia, uremic poisoning (clinical)</b> <b>446 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Bronchopneumonia, left lung, unresolved.</b> DUE TO (c) <b>Nephrosclerosis, bilateral, severe.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 - 5 weeks</b> <b>5 - 6 days</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 4, 1957</b> to <b>January 7, 1960</b> and that death occurred at <b>1:00AM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>1-8-60</b>	
ACTUAL SIGNATURE <b>J. L. Garey</b>		M.D. <b>J. L. GAREY</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL <b>Removal</b>		22b. DATE THEREOF <b>1-8-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		ADDRESS <b>Havre DeGrace, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

0082

Division of Statistics

Washington

Hygiene Division

1941 - six years

Washington Hospital

1940

January 1, 1940

(SHE)

October 1, 1940

Male

1940

Washington

Hygiene

Division

John Johnson

Robert Baker

1940

Washington

Hygiene

Division

1940

1940

Washington

1940

Washington

1940

Washington

1940

1940

1940

1940

1940

1940

1940

1940

1940

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00560

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;"><b>0563</b></span> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point,</b>			c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Street</b> <span style="float: right;"><b>12x-2</b></span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>RFD # 2 Box # 105A</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Robert</b> Middle <b>O.</b> Last <b>Swift</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>8</b> Year <b>19 60</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-12-07</b>	<b>9. AGE</b> (In years last birthday) <b>52</b> yrs.	<b>IF UNDER 1 YEAR</b> Months      Days      Hours      Min.		<b>IF UNDER 24 HRS.</b> Hours      Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Not Ascertainable</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Buffalo, New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Charles A. Swift</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Winifred Johnson</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Not Ascertainable</b>		<b>17. INFORMANT</b> <b>Margaret Swift (W)</b> <span style="float: right;"><b>RFD # 2 Box 105A Street, Md.</b></span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Apparent fracture 2cm long petreus portion of temporal bone, left</b>  <b>936.0</b> DUE TO  <b>Left subdural hemorrhage</b>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> DUE TO  <b>Right sub arthnoid hemorrhage mid line</b> </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH   <b>24 to 36 hrs</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Numerous contusions over body, ulcer at the pylorus with hemorrhage in the intestines</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently was beaten</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>1-5 1960</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>In house</b>	<b>20f. (City or town)</b> <b>Street, Harford</b>		<b>(County)</b> <b>Md.</b>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Noturol causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <i>R. C. Dodson</i>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <b>R. C. DODSON, M. D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>removal</b>		<b>22b. DATE THEREOF</b> <b>1-9-60</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Southern Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Dublin, Md.</b>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>H. S. Bailey</i>				<b>ADDRESS</b> <b>Harlington Md</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JAN 12 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <i>William S. Frank</i>				<b>DATE</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



0564 CERTIFICATE OF DEATH

Reg. Dist. No.

00561

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pa</i> b. COUNTY <i>Lebanon</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural, Calverton 75 x 3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dayheal Nursing Home</i>		d. STREET ADDRESS <i>Kirkwood</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary W.</i> Middle <i>Swisher</i> Last		4. DATE OF DEATH Jan. 18 1960	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 14, 1870</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>North East Md</i>
13. FATHER'S NAME <i>Christopher Wengate</i>		14. MOTHER'S MAIDEN NAME <i>Sarah M. Flett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		17. INFORMANT <i>Harold Swisher, Kirkwood Pa</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3/16</i> 19 <i>54</i> , to <i>1/18</i> 19 <i>60</i> , that I last saw the deceased alive on <i>1/18</i> 19 <i>60</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Neil Taylor</i> M.D.		ADDRESS (Street, city or town, state) <i>Rising Sun, Md</i> DATE SIGNED <i>1/20/60</i>	
PHYSICIAN'S NAME (Type) <i>Neil Taylor Jr MD</i>		<i>Rising Sun, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/20/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oxford Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Oxford, Chester Co Pa</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M Reed</i>		ADDRESS <i>Rising Sun, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 21 '60</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>10/15/1910</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>05/10/1935</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. DATE OF DEATH <i>11/10/1955</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
15. SIGNATURE OF WITNESS <i>[Signature]</i>		16. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
17. DATE OF REGISTRATION <i>11/15/1955</i>		18. OFFICIAL SEAL <i>[Seal]</i>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00562

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>N.Y.</u> <span style="float: right;">b. COUNTY <u>N.Y.</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, Md.</u>		c. LENGTH OF STAY IN 1b <u>Enroute</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Congers</u> <span style="float: right;"><u>69x-3</u></span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>440 Wells Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Jeanne</u> First <u>C</u> Middle <u>Wukowitz</u> Last				<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>23</u> Year <u>19 60</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6-4-1931</u>			
<b>9. AGE</b> (In years last birthday) <u>28</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Model</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Modeling</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>N.Y.</u>			
<b>13. FATHER'S NAME</b> <u>Anthony Vecchio</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Louis Scalero</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> Address <u>Mrs. Louis Scalero, Congers, N.Y.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractures of left humerus, left temporal bone with</u> <u>816X</u> <span style="float: right;">DUE TO</span> <u>brain tissue exposed frontal bone and occipital bone</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and left clavicle. Laceration 6 inches long top</u> DUE TO (c) <u>of head. Both legs lacerated at knees 3 inches long</u> <u>abrasions hand and face.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Car was hit by another one driving in wrong lane</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>6:35</u> a. m. <u>1</u> 23 19 60 p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Route 40</u>			
<b>20f. (City or town)</b> <u>Elkton</u>		<b>(County)</b> <u>Cecil</u>		<b>(State)</b> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>R. C. Dodson</u>		<b>EXAMINER'S NAME (Type)</b> <u>R. C. Dodson</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>22b. DATE THEREOF</b> <u>1-24-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>New York City, N. Y.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>PIPPIN FUNERAL HOME</u>		<b>ADDRESS</b> <u>Elkton, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JAN 26 '60</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Hanna</u>		<b>DATE SIGNED</b> <u>1-24-60</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF DEATH		24. SIGNATURE OF DEATH	
25. SIGNATURE OF DEATH		26. SIGNATURE OF DEATH		27. SIGNATURE OF DEATH	
28. SIGNATURE OF DEATH		29. SIGNATURE OF DEATH		30. SIGNATURE OF DEATH	
31. SIGNATURE OF DEATH		32. SIGNATURE OF DEATH		33. SIGNATURE OF DEATH	
34. SIGNATURE OF DEATH		35. SIGNATURE OF DEATH		36. SIGNATURE OF DEATH	
37. SIGNATURE OF DEATH		38. SIGNATURE OF DEATH		39. SIGNATURE OF DEATH	
40. SIGNATURE OF DEATH		41. SIGNATURE OF DEATH		42. SIGNATURE OF DEATH	
43. SIGNATURE OF DEATH		44. SIGNATURE OF DEATH		45. SIGNATURE OF DEATH	
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94. SIGNATURE OF DEATH		95. SIGNATURE OF DEATH		96. SIGNATURE OF DEATH	
97. SIGNATURE OF DEATH		98. SIGNATURE OF DEATH		99. SIGNATURE OF DEATH	
100. SIGNATURE OF DEATH		101. SIGNATURE OF DEATH		102. SIGNATURE OF DEATH	